ARTICLE 15

SECTION 3

# THIRD PARTY LIABILITY CLAIMS

## 1. GENERAL

Medi-Cal beneficiaries are required to reimburse the Medi-Cal Program for costs of health care services when the beneficiary receives payment for care from a third party such as an insurance company or from a lawsuit. This section provides policies and procedures regarding collection and processing of third party liability information.

## 2. COUNTY RESPONSIBILITIES

### A. Notification to the State

MEM 50771

#### 1) Criteria

The worker is required to notify the State Department of Health Services (SDHS) when:

MEM PROC. 15B

a) Information on the Statement of Facts or from other sources indicate potential third party liability; and

b) The beneficiary is eligible to Medi-Cal; and

c) The beneficiary intends to use Medi-Cal to pay for injury-related services; or

d) The beneficiary or his/her representative has initiated an insurance claim; workers' compensation claim; or wrongful death, malpractice, or similar civil suit against a potentially liable third party.

#### 2) Form DHS 6168 (1/98), Potential Third Party Liability

ACWDL 04-19

Form DHS 6168 (1/98), formerly CWC 6041, is used to transmit third party liability information to SDHS (see Appendix 15-3-A). The worker will:

a) Provide Form DHS 6168 to the client; and

b) Review the form for completeness. To be complete, Form DHS 6168 must have the following information:

(1) Medi-Cal beneficiary's name. If a minor, the parent's/guardian's name should also be given.

(2) Current address and telephone number.

(3) 14 digit County ID number (for example: 37-64-2303457-2-01). All numbers for the individual must be reported.

(4) Social Security number.

(5) Date of birth

(6) Date of injury.

(7) Where injury occurred.

(8) Name, address, and telephone number of third-party recovery source(s) (i.e., attorney, insurance company, etc.) [if available].

(9) Name of person responsible for accident/injury.

(10) Name, address, and telephone number of providers of health care and dates of service (if available).

(11) For workers' compensation claims, the name, address, and phone number of the employer and the worker's compensation case number.

NOTE: Worker should get as much information as possible.

c) File a copy in the case; and

d) Send the original to clerical to batch and mail.

Department of Health Services
Casualty/Workers Compensation Section
P. O. Box 2471
Sacramento, CA 95811-2471

e) If additional information becomes available, send a copy of the original Form DHS 6168 with the additional information.

B. Sources of Information for the Worker

Information from any of the following sources will require evaluation of third party liability status by the worker. County Policy

1) Statement of Facts

a) Is the illness/injury the responsibility of a third party?

b) Benefits from DIB or workers' compensation require worker follow-up for third party liability.

c) Has the applicant received money from insurance or court settlements?

2) Forms CA 7/MC 176 - Periodic Reporting Forms

Any mention of a beneficiary's involvement in an accident or illness requires that the worker ask about possible third party liability.

C. Client Information

1) Beneficiaries are to be advised of their responsibility to notify their worker if they are involved in an accident where a third party may be liable.

2) The worker should also explain that costs for medical care are paid by the Medi-Cal program. When a settlement is reached through Court action or from any insurance source, Medi-Cal is to be reimbursed from the settlement.

D. Direct Reimbursement to Beneficiary by Liable Third Party

MEM PROC. 15A

When a worker is advised by a beneficiary that he/she has received a check made out to him by a liable third party for services paid for by Medi-Cal, the beneficiary/client should be informed:

1) To not cash the check;

2) To endorse the check as follows: "Pay only to the order of Health Card Deposit Fund;"

3) To include the following information on the back of the check:

a) Dates, place, and items of service for which the check has been issued;

b) Beneficiary's full name;

c) The case number; and,

d) Address of beneficiary.

4) To mail the check to:

Department of Health Services
Recovery Unit – MS 4720
P. O. Box 997421
Sacramento, CA 95899-7421

3. RESPONSIBILITY FOR INVESTIGATION AND RECOVERY ACTIONS

A. The responsibility for **personal injury** investigation and recovery actions on third party liability cases rests with the DHS Recovery Unit.

B. The responsibility for **Workers' Compensation** investigation and recovery actions of third party liability cases rests with the Health Management Systems.

Note: County involvement ends once Form DHS 6168 has been sent to the state.

4. SDHS REPORTS TO COUNTY

When the Casualty/Worker's Compensation section receives payment on an account, written notification is sent to the county where the beneficiary lives. This alerts the county that a settlement was reached which may affect the eligibility of the individual. Form CWC 4000 is used.

The state has no assurance that monies in fact have been received by the named individual. The worker will use this information to review, contact the client for clarification and, if necessary, recompute eligibility.

To: ❒ Department of Health Services
TPL Personal Injury Program-MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

**OR**

❒ Health Management Systems
WC Recovery Program
975 Business Park Drive, Suite 110
Sacramento, CA 95827-1716

Date:_____

Mail: Original
File: Copy

# POTENTIAL THIRD PARTY LIABILITY NOTIFICATION

1. Have you used, **or will you use**, Medi-Cal for your injury or illness? ..... ❒ Yes ❒ No
2. Have you filed, **or will you file**, a lawsuit or insurance claim? ..... ❒ Yes ❒ No

*If you answered **Yes** to one or both of the above questions, complete the following:*

3. Injury/illness occurred at: ❒ Home ❒ School ❒ On someone else's property
❒ Work ❒ Motor vehicle ❒ Other_____

| Case name (first, middle, last) | | | Date of injury or illness *(DATE MUST BE PROVIDED.)* | |
|---|---|---|---|---|
| Address (number, street) | City | State | ZIP code | Social Security number - - |
| Mailing address | City | State | ZIP code | Telephone number ( ) |

**Injured Persons(s):**

| Name | Date of Birth | County Code | Aid Code | Social Security Number (If not available, Medi-Cal or CIN) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

4. Have you filed, **or will you file**, a lawsuit? ❒ Yes ❒ No If yes, please provide the following information:

| Attorney name | | Telephone number ( ) | |
|---|---|---|---|
| Mailing address | City | State | ZIP code |

5. Is there insurance (other than Medi-Cal/Medicare) **covering you or anyone else** for this injury/illness (auto, homeowners, premise liability, accident, health)? ❒ Yes ❒ No If yes, please provide the following information:

| Insurance company | | Telephone number ( ) | |
|---|---|---|---|
| Mailing address | City | State | ZIP code |
| Claim adjuster | Claim/policy number | Policy holder | |

**WORK RELATED INJURY**

Have you filed an application for Workers' Compensation benefits? ❒ Yes ❒ No

| Employer at time of accident | Telephone number ( ) | Workers' Compensation claim/case number | |
|---|---|---|---|
| Mailing address | City | State | ZIP code |

***DO NOT WRITE BELOW THIS LINE***

**COUNTY USE ONLY**

| Eligibility worker | Worker number | County | Telephone number ( ) |
|---|---|---|---|

DHS 6168 (1/98) (formerly CWC 6041)